Connecticut Psychiatric Society

A District Branch of the

American Psychiatric Association

TESTIMONY IN FAVOR OF H.B. 7125

AN ACT CONCERNING PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS, NONQUANTITATIVE TREATMENT LIMITATIONS, DRUGS PRESCRIBED FOR THE TREATMENT OF SUBSTANCE USE DISORDERS, AND SUBSTANCE ABUSE SERVICES.

Good Afternoon. My name is Shaukat Khan. I am a psychiatrist and president of the Connecticut Psychiatric Society, an organization representing over 800 psychiatrists in this state. Psychiatrists are medical doctors, specializing in the treatment of mental illness and substance use disorders. I work as a psychiatrist at the VA Connecticut Health Care System in West Haven and also at the Yale Behavioral Health Services at Hamden. Information I provide here includes my personal experiences as well as experiences shared by some of my colleagues.

We support House Bill 7125, and I would like to give you a few examples from our perspectives as to why it is necessary.

As many speakers will tell you, a major difficulty with implementing parity laws is the benefits that are "non-quantifiable." Those are differences in care that can't be easily identified except through comparing statistics across large populations. Regular disclosure by the insurance plans is needed for having such statistics, which is largely lacking now.

From a psychiatric perspective, we see several problems that appear discriminatory—probably the most prominent is the lack of referral to appropriate care after a patient has left a hospital. Patients are typically admitted to a hospital only for the most extreme conditions. They are very ill and at risk of harming themselves or others. Some of them are trying to overcome substance use disorders. But third party payers often will not authorize follow-up residential programs and instead mandate treatment on an outpatient basis. This is like saying to a patient with a medical condition "yes, you had a serious medical event and your doctor is recommending a skilled nursing facility for aftercare, but we will only authorize physical therapy *for* few times a week on an outpatient basis." Moreover, sometimes there are limitations in terms of number of days stay in the inpatient unit and number of visits thereafter, arbitrarily imposed by insurance companies, not decided by doctors.

Another example is mandating that patients "fail" on cheaper medications or treatments before more expensive medications or treatments are authorized. If someone had a serious medical condition, would we make them wait until they went through non-effective treatments? Sometimes these more expensive medications are prescribed by the psychiatrists, from the beginning, as these medications are effective to treat more than one condition that the patients present with, which might not be known to the plan reviewers.

Another disturbing example is the lack of appropriately trained practitioners in third party networks. In a recent study, nationwide, nearly 35% of the patients had difficulties in finding the therapist in their network. The effect of not having enough treaters in network is both a huge expense to the patient for care they are already paying for in their premiums and delay in receiving the care they need, thus risking that an illness spirals out of control. Maybe the most common reason for lack of practitioner in the networks is inadequate reimbursement for their services by insurance companies.

We also experience what we see as discrimination in requirements for prior authorization. Psychiatrists are required to submit prior authorizations for medications or services that seem out of proportion to what medical patients are subjected to. The result of this is more overhead for psychiatrists and fewer hours of actual patient care. It is frustrating when I, in my clinic practice, sometimes have to get prior authorization for medications on which the patents have been for many years or for the same medication, only because I'm changing the dose. It is disturbing when I hear from my colleague, who finds his patients require time consuming pre-authorization for their substance use disorder treatment but not for their medical care form a primary care physician who practices in the same building. When the opioid crisis is plunging our state, we should try to remove the barriers for substance use disorder treatment as much as we can, not try to keep those in place.

In the recent years interventional treatment methods, such as, repetitive Transcranial Magnetic Stimulation (rTMS), Vagus Nerve Stimulation (VNS), are gaining popularity in psychiatry. These are more expensive treatment options and will require comparable cost sharing by insurance plans as with other comparable procedures practiced in the Medicine/Surgery. But many of them will recover as aresult of this treatment oand goon to lead productive lives and be contributing members of our society.

Psychiatric services are trying to improve access to care by introducing innovative ways, such Collaborative Care and Telepsychiatry. Those will also need comparable approaches by the plans. Especially for collaborative care services, when often the mental health providers will be co-located with his primary care colleagues to deliver services to the same patients.

As a physician, I'm proud to work for the veterans. There are about 20 million U.S. veterans. Estimated about 25 % of them or 5 million suffer from mental illness. In 2016, about 1.6 million veterans received mental health care from the VA. There are many veterans who receive psychiatric care outside the VA facilities. They are also being affected by lack of parity like the other mentally ill patients.

We understand that you don't approve laws based on anecdotes. Our request is that this law be passed so data can be gathered that back up what we and our patients are experiencing.

Mental illnesses are major causes of deaths and sufferings. National Institute of Mental Health (NIMH) estimated that in 2016, 44.7 million, approximately 1 in 5, American adults have mental illness, almost 50% of us will suffer from a mental illness in our life-times. CDC reports more than 41,000 deaths by suicide in 2013, which are more deaths than are caused by prostate cancer. An estimated total financial cost related to mental illness was $467 billion in 2012. Mental Illness, thus, needs equal priority, if not more, as other health services.

For many years Connecticut led the way to parity. We hope that you will continue that practice so we can deliver on the promises parity makes to patients.

Thank you for your attention.

I would also point out that we have submitted written testimony on H.B. 7261, AN ACT PROHIBITING REQUIREMENTS FOR PRESCRIBING CLINICALLY INAPPROPRIATE QUANTITIES OF OUTPATIENT PSYCHOTROPIC DRUGS. I will be here if you have any questions on our testimony in favor of that bill.